STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012802	A. BUILDING: _____ B. WING _____	C 04/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED AT HOME-HOME HEALTH-INDIANAPOLIS	2415 DIRECTORS ROW, SUITE C INDIANAPOLIS, IN 46241

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments This was a state home health complaint investigation. Complaint # IN00168997: Allegation did not occur. Facility Number: 012802 Medicaid number: 201081750 Kindred At Home - Home Health- Indianapolis is in compliance with 410 IAC, Article 17, Rule 12, Section 1 as relates to this complaint. QA:JE 4/14/15	N 000		